

Register 107; am 1/18/90, Register 113; am 4/12/90, Register 114; am 9/21/90, Register 116; am 8/6/92, Register 123)

Authority: AS 47.07.070

AS 47.07.073

AS 47.07.180

7 AAC 43.687. METHODOLOGY AND CRITERIA FOR ADDITIONAL PAYMENTS AS A DISPROPORTIONATE SHARE HOSPITAL. (a) An acute care hospital providing services to a disproportionate share of Medicaid patients is eligible for additional payments for Medicaid services effective July 1, 1988.

(b) Medicaid inpatient hospital rates will be adjusted for an acute care hospital that meets the following disproportionate share criteria:

(1) two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to Medicaid patients; and either

(2) Medicaid inpatient utilization at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals in the state; or

(3) a low-income inpatient utilization rate exceeding 25 percent; the low-income inpatient utilization rate is calculated as follows: the total Medicaid inpatient hospital revenue paid to the hospital in the hospital's base year, plus the amount of the tax revenue as described in 7 AAC 43.685(b)(4)(B) in the hospital's base year, divided by the total amount of hospital revenue for inpatient services (including the amount of tax revenues) for the hospital's base year; plus the hospital's charges for inpatient hospital services attributable to charity care, as defined in the manual, for the hospital's base year, divided by the total amount of the hospital's charges for inpatient services in the same period.

(c) For a hospital located outside of a Metropolitan Statistic Area, as defined by the federal Executive Office of Management and Budget, "obstetrician" in (b)(1) of this section includes any physician with staff privileges at the hospital who will perform nonemergency obstetric procedures. Criterion (b)(1) of this section does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age, nor to a hospital that does not offer non-emergency obstetric services.

(d) The disproportionate share adjustment will be calculated as an additional percentage to be added to the department approved prospective payment rate as follows:

(1) by June 1 of each year, the Medicaid inpatient utilization rate will be calculated for an acute care hospital based on utilization during the hospital's most recently completed fiscal year; by May 1, a hospital wishing consideration as a disproportionate share hospital must report the amount of total charges for inpa-

tient services, total inpatient revenue, Medicaid inpatient hospital revenue received, tax revenue as described in 7 AAC 43.685(b)(4)(B), and inpatient charity care charges, as defined in the manual, for the facility's base year;

(2) a hospital that meets the requirements of (b)(2) or (3) of this section shall provide the names and Medicaid provider number of at least two physicians meeting the requirements of (b)(1) of this section, if obstetrical services are applicable;

(3) the additional disproportionate share payment will be the greater of one percent or the difference between the hospital's Medicaid inpatient utilization and one standard deviation above the mean Medicaid inpatient utilization rate for hospitals in the state;

(4) the disproportionate share payment is not subject to the payment limitations in 7 AAC 43.685(d).

(e) Disproportionate share payments will be phased in over a three-year period. As of July 1, 1988, the adjustment will be one-third of the amount of the full payment adjustment. As of July 1, 1989, the payment will be two-thirds of the full payment adjustment. As of July 1, 1990, the payment will be the full payment adjustment. (Eff. 3/16/89, Register 109; am 8/25/89, Register 111; am 8/6/92, Register 123)

Authority: AS 47.07.040

AS 47.07.070

7 AAC 43.688. TOTAL FINANCIAL REQUIREMENTS. Repealed 8/9/86.

7 AAC 43.690. OPERATING COSTS. Repealed 8/9/86.

7 AAC 43.691. YEAR-END CONFORMANCE. (a) To determine whether the rates paid to a facility are in conformance with the department-approved rates, the department will conduct a year-end review as follows:

(1) The actual depreciation will be substituted for the approved depreciation when considering year-end conformance.

(2) For long-term care facilities and intermediate care facilities for mentally retarded, the department will compare the actual costs per day to the approved rate, with actual ancillary costs substituted for the approved ancillary costs. Actual ancillary costs will be calculated based on the ratio of operating expenses, less revenue offsets defined in 7 AAC 43.685(b)(4), to charges in the applicable ancillary revenue center. For a facility with a fiscal year under review beginning on or after January 1, 1995, actual ancillary costs will be calculated based on the ratio of operating expenses, less

revenue offsets defined in 7 AAC 43.685(b)(4), to charges in the applicable ancillary revenue center, not to exceed 100 percent of usual and customary charges. The following apply to the ancillary costs:

(A) If actual costs are less than two percent below or above the approved rate, adjusted for actual ancillary costs, no adjustments will be made.

(B) If actual costs are two percent or more below the approved rate, adjusted for actual ancillary costs, the actual ancillary costs will be compared to the approved ancillary costs. If actual ancillary costs are below the approved ancillary costs, 90 percent of the difference will be reduced from the rate as approved by the department in the facility's next fiscal year. If actual ancillary costs are above the approved ancillary costs, 90 percent of the difference will be added to the rate as approved by the department in the facility's next fiscal year.

(b) For acute care hospitals and specialty hospitals, the department will compare the actual charges billed to the division of medical assistance with the approved rate per adjusted admission. If the actual charges to the division of medical assistance exceed the allowable costs as calculated in the approved budget and adjusted in (a) of this section, the percentage of charges will be adjusted downward in the facility's next fiscal year by the amount of the difference.

(c) Repealed 7/20/88.

(d) For rural health clinics, the department will compare the actual costs for each visit to the approved rate and.

(1) if actual costs for each visit for medical assistance recipients are equal to or above the approved rate, no adjustments will be made;

(2) if actual costs or charges for each visit for medical assistance recipients are below the approved rate, the difference between the approved rate and actual costs or charges, whichever is less, will be deducted from the rate approved by the department for the rural health clinic's next fiscal year.

(e) The department will, in its discretion, waive all or part of the year-end conformance if the facility provides justification, to the department's satisfaction, that manifest irreparable injustice will result if year-end conformance is strictly applied, and if the department finds that

(1) the facility has taken effective measures to control costs in response to the situation upon which the waiver request is based;

(2) the waiver request does not contradict a prior action of the department as to an element of the facility's rate established under 7 AAC 43.683, 7 AAC 43.685, or 7 AAC 43.686;

(3) the waiver request would result in payment for only allowable cost of services authorized by the division of medical assistance under state or federal laws, or both if applicable, or under regulations; and

(4) the situation upon which the waiver request is based results from the provision of direct patient care or from prudent management actions improving the financial viability of the facility to provide patient care.

(f) Outpatient surgical clinics and hospital outpatient laboratory services are exempt from all provisions of this section. (Eff. 8/9/86, Register 99; am 5/8/88, Register 106; am 6/19/88, Register 106; am 7/20/88, Register 107; am 3/25/89, Register 109; am 8/6/92, Register 123)

Authority: AS 47.07.070

AS 47.07.071

AS 47.07.180

7 AAC 43.692. FUNDED DEPRECIATION. Repealed 8/9/86.

7 AAC 43.693. FACILITY AUDITS. (a) The department will inspect the financial records of a facility receiving payments from the division of medical assistance. The department will inspect financial records during normal business hours and will notify a facility of a proposed inspection of its records at least 10 working days before the inspection.

(b) If the department directs, a facility receiving payments from the division of medical assistance for eligible state program recipients shall produce its financial records for inspection by the department at a location within the state or at another place agreed upon by the department and the facility.

(c) At the request of the department, a facility shall send copies of financial records to the department offices within 10 working days after the request is received.

(d) The department will review the findings of facility audits. Audit findings that determine that the division of medical assistance has overpaid or underpaid will be acted upon by the department in the following manner:

(1) If the audit findings relate to a facility's fiscal year already ended, the division of medical assistance will be notified of amounts due from or to the facility.

(2) If the audit findings relate to a facility's fiscal year in progress, the approved rate will be adjusted to reflect a correct payment rate. The level of adjustment will be prorated to ensure that the division of medical assistance will recoup all money by the end of the facility's fiscal year or that the facility will receive all money due it, as appropriate. (Eff. 8/9/86, Register 99; am 8/6/92, Register 123)

Authority: AS 47.07.070

AS 47.07.074

7 AAC 43.694. UNIFORM SYSTEM OF BUDGETING AND FINANCIAL REPORTING. Repealed 8/9/86.

7 AAC 43.695. OBRA '87-RELATED CONTINUING EDUCATION FOR NURSE AIDES. (a) For the period beginning July 1, 1989 and ending September 30, 1990, each long-term care facility may submit a cost report to the commission, prepared on forms provided by the commission, which details the facility's actual incremental costs and hours of training and competency evaluation activities resulting from OBRA '87-related nurse aide training requirements (Omnibus Budget Reconciliation Act of 1987; 42 U.S.C. 1396). These incremental costs may include associated recordkeeping costs and a testing fee for individual nurse aides, but may not include the cost of any license fee. Upon the department's receipt, review, and approval of the completed cost report, the department will make a lump sum payment to the facility to reimburse actual long-term care facility allowable costs identified in the cost report. The actual costs reported in the cost reports and the related payments are subject to audit and adjustment by the department.

(b) For facility fiscal years that end after October 1, 1990, each long-term care facility may submit with its year-end report, in accordance with the requirements of 7 AAC 43.679(c), a cost report, prepared on forms provided by the commission, which details the facility's actual incremental costs and hours of training and competency evaluation activities resulting from OBRA '87-related nurse aide training requirements. These incremental costs may include associated recordkeeping costs and a testing fee for individual nurse aides, but may not include the cost of any license fee. Upon the department's receipt, review, and approval of the completed cost report, the department will make a lump sum payment to the facility to pay actual nurse aide training and evaluation allowable costs, subject to hour limits in this subsection. Hour limits on continuing education for nurse aide costs are as follows:

(1) 17 hours each year of continuing education for each nurse aide on the staff of the facility;

(2) 50 hours of training for each new nurse aide on the staff of the facility. (Eff. 9/21/90, Register 116; am 8/28/91, Register 119)

Authority: AS 47.07.070

AS 47.07.073

7 AAC 43.696. YEAR-END REPORTING AND CONFORMANCE. Repealed 8/9/86.

7 AAC 43.697. GENERAL PROCEDURES APPLICABLE TO INFORMAL COMMISSION PROCEEDINGS. (a) Continuances.

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A person who desires a continuance of a proceeding before the commission must, as soon as facts requiring such a continuance come to his or her knowledge, notify the commission. The notice must identify the interest of the person in the proceeding as well as the reasons why a continuance is necessary. Except in cases of hardship or unless good cause is shown, a continuance will not be granted unless a request is made to the commission at least three days before the date upon which the matter is set for proceeding. The commission will, in its discretion, grant a continuance, and will, in its discretion, at any time, order a continuance upon its own motion. During the proceeding, if it appears in the public interest that further testimony or argument should be received, the presiding officer may continue the proceeding and fix the date for introduction of additional testimony or presentation of argument. Such an oral notice constitutes final notice of a continued proceeding. The granting of a continuance by the commission could result in a concurrent suspension of the effective date of proposed rates.

(b) Classification of parties. The state, including the division of medical assistance, is a party to all proceedings before the commission. Other parties to proceedings before the commission are either applicants, intervenors, petitioners, or protestants, according to the nature of the proceeding and the relationship of the parties to the proceeding, as follows:

(1) Applicant: A facility applying for a commission recommendation for a right or authority from the department, including an approved rate or a change in rate, is an "applicant."

(2) Intervenor: A person permitted to intervene, as provided in (c) of this section, is an "intervenor."

(3) Petitioner: A person petitioning for the opportunity to intervene, or for other relief, is a "petitioner."

(4) Protestant: A person, including the commission staff, opposing a petition or an application, or seeking the disapproval or modification of a request in a petition or application, is a "protestant."

(c) Intervention.

(1) General intervention: A person who desires to appear and participate in a proceeding before the commission may, before or at the time of the informal proceeding, petition in writing for permission to intervene in the proceeding, or may, at the time of the proceeding, make an oral motion for permission to intervene. Such a petition or motion may not be filed or made after the proceeding is underway, except for good cause shown. The petition or motion to intervene must disclose the name and address of the person intervening; the name and address of the person's attorney, if any; and the person's interest in the proceeding and position in regard to the matter before the commission. A written petition must be

filed with the commission and copies must be provided to all other parties to the proceeding.

(2) Disposition of a petition to intervene: A petition to intervene will, in the commission's discretion, be heard before the presentation of evidence in the proceeding, or set for prior proceeding. An opportunity will also be afforded all other parties to be heard. If it appears that the petition discloses a substantial interest in the subject matter of the proceeding, or that participation of the petitioner might be in the public interest, the commission will, in its discretion, grant the petition; the granting will, in the commission's discretion, be by oral order at the time of the proceeding. After that, the petitioner is a party to the proceeding and is known as an "intervenor," with the same right to produce witnesses and to cross-examine as other parties to the proceeding. If it appears, during the course of a proceeding, that an intervenor has no substantial interest in the proceeding, and that the public interest will not be served by the intervention, the commission will, in its discretion, dismiss that person from the proceeding after notice and a reasonable opportunity to be heard.

(d) Appearances.

(1) A party shall enter its appearance by giving its name, address, and the party represented, if any, in writing to the commission and all other parties. After that, all future notices, pleadings, and orders may be served upon that representative, and that service is considered valid service for all purposes upon the party represented. The presiding officer conducting the proceeding may, in addition, require appearances to be stated orally, so that the identity and interest of all parties present will be known to those at the proceeding.

(2) No person may appear in a representative capacity before the commission other than as follows:

(A) representatives who have demonstrated to the commission's satisfaction qualifications to practice before the commission;

(B) representatives of the state and the United States Department of Health and Human Services; and

(C) upon permission of the presiding officer at a proceeding, a bona fide officer, trustee, director, or full-time employee of an individual, partnership, association, corporation, comprehensive health planning agency, or facility, who appears for the planning agency or facility.

(e) Conduct at proceedings. A party to a proceeding, the party's counsel, and spectators, shall conduct themselves in a respectful manner. Demonstrations of any kind at a proceeding are not permitted.

(f) Order of procedure. A request for a continuance will be considered first in a proceeding regarding annual budget submittals. If two or more annual budget submittals are set for proceeding at the same time and place, the commission will usually hear the matters in the same order as they appear in the agenda.

(g) Number of witnesses and duration of testimony may be limited. In all proceedings before the commission, the presiding officer may limit not only the number of people making presentations or witnesses testifying upon any subject or proceeding before the commission, but also the length of time allowed for presentations and the giving of testimony, as long as sufficient testimony has been received to enable the commission to render a fair and impartial decision.

(h) Burden of proof. At an advisory proceeding involving a recommendation for change in commission staff recommended rate, schedule, classification, rule, or regulation, the effect of which is, if adopted by the department, to change a rate previously charged, the burden of proof to show that the change meets the requirements of AS 47.07 is on the proponent of the change.

(i) Appearances and attendance at informal proceedings.

(1) The presiding officer conducting an advisory proceeding may require representatives of the facility, commission staff members responsible for the statement of findings and recommendation, and members of the general public who have submitted written testimony regarding the facility's annual budget submittal, who are in attendance, to orally identify themselves and state their addresses and their interest in the matter to be considered by the commission, so that the identity and interest of those persons will be known to those at the proceeding. Representatives of the facility are not required to attend the advisory proceeding conducted by the commission regarding that facility's annual budget submittal.

(2) Presentations and testimony to the commission during informal proceedings must be given in the following order, unless the presiding officer directs a different order to suit the convenience of all participants:

(A) the summarization of the matter, and presentation of commission staff findings and recommendations by the executive director or his or her designee;

(B) the response by the facility;

(C) answers to questions asked by the commission;

(D) any comments by other persons or parties in attendance;

(E) any response by the facility, commission staff, or the commission, to comments.

(j) Record of informal proceeding. Each proceeding before the commission will be electronically recorded by the staff. The commission's secretary will record a summary of the testimony presented to

the commission as well as all questions asked by commission members and the responses given. The electronic recording and the summary, together with the facility's annual budget submittal and response, if any, the commission staff statement of findings and recommendations, and written testimony submitted by the general public, constitutes the record of the commission's informal proceeding.

(k) Questions by commission members. At any point during an informal proceeding, questions may be asked by commission members of any party or other person in attendance.

(l) Repealed 3/13/89.

(m) Repealed 3/13/89.

(n) Commission recommendation. The commission will, in its discretion, consider the request for a change in a schedule, classification, rule, or regulation, for a prospective payment rate, or for change of a prospective payment rate. The commission will, in its discretion, offer recommendations to the department regarding proposed action to be taken. If a recommendation is made regarding a rate or change in rate, the commission shall make findings concerning amounts allowable under 7 AAC 43.670 — 7 AAC 43.709, amounts not allowable under 7 AAC 43.670 — 7 AAC 43.709, the additional amounts recommended for exceptional relief under 7 AAC 43.708, and any other factors that the commission finds are relevant. The commission shall notify the executive director of the commission, the division of medical assistance, and the commissioner of the department of any recommendations made under this subsection. (Eff. 8/9/86, Register 99; am 7/20/88, Register 107; am 3/13/89, Register 110; am 10/11/89, Register 112)

Authority: AS 47.07.070

AS 47.07.180

7 AAC 43.698. COST ALLOCATION SYSTEM. Repealed 8/9/86.

7 AAC 43.699. ADMINISTRATIVE APPEAL. Repealed 3/13/89.

7 AAC 43.700. HEALTH FACILITY AUDITS. Repealed 8/9/86.

7 AAC 43.701. ESTABLISHMENT OF THE PROSPECTIVE PAYMENT RATE. (a) Based on the consideration of the documents submitted by the facility, recommendations of the commission staff, recommendations of the division of medical assistance, testimony before the commission, recommendations of the commission, and the consideration of applicable law and regulation, the executive director of the commission shall establish the prospective payment rate. The executive director of the commission shall notify the facility, the division of medical assistance, and the commission of the decision estab-

lishing the prospective payment rate and factors on which the decision was based.

(b) The executive director of the commission may accept a request for reconsideration, either under his or her own motion or at the request of a party, of an action taken and prospective payment rate set, within 30 days after the date of the mailing of the notice of a decision. The executive director shall consider a request for reconsideration as untimely filed if the executive director has not received it within 30 days after the executive director's mailing of the notice of the decision of the party. (Eff. 3/13/89, Register 110)

Authority: AS 47.07.070

7 AAC 43.702. BURDEN OF PROOF. Repealed 8/9/86.

7 AAC 43.703. ADMINISTRATIVE APPEAL. (a) A party aggrieved by a decision of the executive director under 7 AAC 43.701 may, within 30 days after the date of the decision, request reconsideration under 7 AAC 43.701(b) or may request an administrative appeal to the commissioner of the department.

(b) If a request for reconsideration under 7 AAC 43.701(b) is denied, or if a party is aggrieved by the decision of the executive director on the reconsideration, the party aggrieved by the decision may, within 30 days after the date of the decision, request an administrative appeal to the commissioner of the department.

(c) If a decision of the executive director is appealed to the commissioner, the prospective payment rate set by the executive director will be effective subject to adjustment based on the commissioner's decision on the administrative appeal. The commissioner will, at his or her discretion, provide copies of the commissioner's proposed decision to the commission. (Eff. 3/13/89, Register 110)

Authority: AS 47.07.070

AS 47.07.180

7 AAC 43.708. EXCEPTIONAL RELIEF TO PROSPECTIVE PAYMENT RATE SETTING. (a) If application of the methodology in 7 AAC 43.676 — 7 AAC 43.691 results in a permanent prospective payment rate that does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the facility may apply to the deputy commissioner of the department for exceptional relief from the rate-setting methodology.

(b) To apply for exceptional relief under (a) of this section, at a minimum the facility's application should include

(1) the amount by which the facility estimates that the prospective payment rate should be increased to allow reasonable access to quality patient care provided by an efficiently managed facility;